

9549

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, that it may be properly classified. If any item can not be obtained insert word "unknown." Make every effort possible to secure this information. Incorrect certificates will be returned for correction.

PLACE OF DEATH		ARIZONA STATE BOARD OF HEALTH	
BUREAU OF VITAL STATISTICS		State Index No. 105	
County <u>Graham.</u>	District _____	County Registered No. <u>69</u>	
Town _____	Or City _____	Local Registrar's No. <u>58</u>	
No. _____ (If death occurred in a Hospital or Institution, give its NAME instead of street and number.)			
FULL NAME <u>Delia Preston</u>			
PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>Female</u>	Color or Race <u>White</u>	SINGLE <u>Single</u>	
	White Indian	MARRIED	
	Black Chinese	WIDOWED	
	Mexican	or DIVORCED	
DATE OF BIRTH <u>7</u>	<u>24</u>	<u>1907</u>	
	(Month) (Day) (Year)		
AGE <u>13</u>	yrs. <u>4</u> mos. <u>4</u> days	If less than 1 day _____	
OCCUPATION			
(a) Trade, profession or particular kind of work <u>None</u>			
(b) General nature of industry, business, or establishment in which employed or (employer) <u>none</u>			
BIRTHPLACE (State or country) <u>Canada</u>			
PARENTS			
NAME OF FATHER <u>William F. Preston</u>			
BIRTHPLACE OF FATHER (State or country) <u>East Hertfordshire</u>			
MAIDEN NAME OF MOTHER <u>Bessie E. Rogers</u>			
BIRTHPLACE OF MOTHER (State or country) <u>Prima and ...</u>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>William F. Preston</u>			
(Address) <u>Prima</u>			
PLACE OF BURIAL OR REMOVAL <u>Prima</u>		DATE OF BURIAL OR REMOVAL <u>1920</u>	
UNDERTAKER		ADDRESS	
MEDICAL CERTIFICATE OF DEATH			
DATE OF DEATH <u>8</u> <u>15</u> <u>1920</u>			
(Month) (Day) (Year)			
I hereby certify, that I attended deceased from <u>Aug 7th</u> <u>1920</u> to <u>Aug 15</u> <u>1920</u> ; that I last saw her alive on <u>Aug 15</u> <u>1920</u> and that death occurred on the date stated above at <u>2:35 P.M.</u> The DISEASE or INJURY causing death was as follows: <u>Traumatic Infection</u>			
(Duration) _____ yrs. _____ mos. _____ days <u>8</u>			
Was disease contracted in Arizona? <u>Yes</u>			
If not, where? _____			
CONTRIBUTORY <u>Immunity Septic</u>			
(Duration) _____ yrs. _____ mos. _____ days <u>8</u>			
(Signed) <u>J. N. Morris</u>			
1920 (Address) <u>Suffolk</u>			
*In deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
LENGTH OF RESIDENCE			
At place of death _____ yrs. _____ mos. _____ ds. In Arizona _____ yrs. _____ mos. _____ ds.			
Former or Usual Residence			
Filed _____			
1920 <u>Alma Burns</u>			
Local Registrar			
1920 <u>J. N. Stratton</u>			
County Registrar			